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AUTHOR	Cohen, Jordan J.
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ABSTRACT

This address by the Association's president outlines the role of the Association of American Medical Colleges (AAMC) and the medical education community in responding to the changing nature of the American health care system and medical education. It focuses on: (1) establishing true medical school-community partnerships; (2) elevating prevention and health maintenance; (3) addressing social problems, such as substance abuse, teenage pregnancy, and violence; (4) containing health care costs; (5) harnessing information technology; (6) fostering racial, ethnic, and gender parity; (7) solidifying status with policymakers; and (8) restructuring and downsizing, including helping meet workforce needs, transforming teaching hospitals, developing regional education consortia, becoming a learning network, and creating a permanent planning process. (MDM)

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LEARNING TO CARE, *for a* HEALTHIER TOMORROW

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Jordan J. Cohen, M.D.
President
Association of American Medical Colleges

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Learning to Care, for a Healthier Tomorrow

Jordan J. Cohen, M.D.

This article is a slightly edited version of the President's Address presented at the Plenary Session of the 106th Annual Meeting of the Association of American Medical Colleges (AAMC), held in Washington, D.C., October 27–November 2, 1995. Dr. Cohen is president of the AAMC, Washington, D.C.

Our country is undergoing a historic transformation in the way health care is organized, delivered, and financed, and academic medicine is headed, without question, toward a future that will be far different from the past. We in academic medicine have a clear choice. Either we can transform ourselves, or we can stand by while others do the transforming for us.

I take as a given that we want academic medicine to take charge of its own future. But, what kind of future are we talking about? What do we wish to preserve from the rich heritage that we have been privileged to enjoy? And what do we concede is now wanting and outdated that we now have an opportunity to revamp? The AAMC's strategic plan offers us a variety of ways for seeking answers to those questions and I, for one, have no doubt that we will find them. Other industries have faced precisely the same questions, and other industries have found the right answers for themselves.

Did he say industries? *Does he really think we can use industry as a model?* You bet I do. Academic medicine *is* an industry. I know we don't like to think of ourselves that way. But, stripped to the core, that's clearly what we

are. And we shouldn't be ashamed to say so. The image of an industry as a grimy, mindless, clanking of machinery, grinding out indistinguishable widgits, is a myopic and outmoded caricature. The reality is: Successful industries make things and provide services that people want and need. People want and need well-educated and highly trained physicians, new medical knowledge, and high-quality medical care. That's what our industry makes!

But no industry, however successful, can expect to go on doing business the same way indefinitely. The desires of people change. Their needs change. The world changes. Successful industries change to meet—and to create—new expectations and new realities. And, like it or not, our customers are beginning to express many new expectations and to raise many troubling questions about each one of our products—education, research, and clinical services. Are we training the right number and kinds of physicians? Why does our education cost so much? Do we need to re-balance our research agenda with more emphasis on getting products to market faster and doing a more effective job taking care of people with the knowledge we already have? Why are the prices of our health care services so high?

Academic medicine is an industry.... People want and need well-educated and highly trained physicians, new medical knowledge, and high-quality medical care. That's what our industry makes!

That so many questions and concerns are now being raised about our industry should not surprise us. Nor should it discourage us. What we are witnessing is simply the inexorable consequence of change. None of us needs to be reminded that *change is the only constant in the equation of progress.*

And some of the most spectacular progress ever made in the science and practice of medicine has occurred while we and our predecessors in academic medicine have been in the driver's seat. We are being challenged now to drive our industry—and each of its production lines—into better alignment with the changing needs and expectations of our customers: our students, our patients, the public. That's easy to say, but where do we begin? Answer: with a shared vision about where it is we want to go. Change without a vision is a ticket to the wrong destination. And I don't believe we have a clear vision at the moment, but I do believe we must begin together to craft one if we hope to end up in the right place.

A Shared Vision

So, allow me to get the ball rolling by offering my vision of where academic medicine should choose to go. To begin with, here is the credo for my vision—Learning how to care, for a healthier tomorrow. What learning should mean, it seems to me, is not only what our students and residents do to master their profession, or what our medical scientists do to discover nature's secrets, or what our academic clinicians do to improve the effectiveness of medical care. Learning also means what our collective enterprise does to understand—and respond to—the needs of our society.

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Establishing True School—Community Partnerships

In my vision, true partnerships would be established between medical schools and their associated clinical enterprises, on the one hand, and the communities they serve, on the other. The AAMC's Outstanding Community Service Award, now in its third year, and the David E. Rogers Award inaugurated at this meeting, would be the most prestigious and coveted accolades a school or individual could receive. Through intensified public dialogue, such partnerships would be the vehicles by which individuals and families living in communities throughout the country would become better informed about their essential roles in maintaining their own health. Likewise, the institutions of academic medicine would become much better informed about the needs in their regions for various kinds of health care providers, and about the solvable health problems that require attention by investigators and clinicians.

Our image of academic medicine as a stool with supporting legs is in danger of toppling over as insufficient public support threatens to pull the rug

out from under us. If we are to set it right, we need to add a fourth leg of equal length and strength to the teaching, research, and health care supports—a fourth leg of public health to provide the needed stability for an otherwise shaky perch from which to uphold our societal missions and maintain the public's trust.

Elevating Prevention and Health Maintenance

In my vision, our focus on population-based medicine would be broadened substantially as a means for elevating prevention and health maintenance to equal status with diagnosis and treatment in our education, research, and patient care programs. The concerns emanating from population-based medicine would then permeate medical education as pervasively as the insights emerging from molecular and cellular biology. A useful vehicle for achieving this goal is the AAMC's new Medical School Objectives Project, one of the prominent features of our strategic plan and described in some detail in the Association's annual report. As a corollary to this vision, the gulf separating medicine and public health would finally be bridged. The activities of the AAMC and the American Public Health Association would be thoroughly integrated, as would all of the activities of the medical and public health profession. Full mergers of schools of medicine and schools of public health would accelerate the overdue annealing of the historic, but arbitrary and counterproductive, cleavage of what is fundamentally a single organic enterprise.

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As a long-term consequence of our community partnerships, and of our attention to population-based concerns, we could envision that our country's health status would steadily improve. And the outrageous disparity in health status between the majority and minority members of our own society would begin to disappear. Childhood immunization rates would

increase; tobacco use would fall; and our country's high rates of infant mortality and prematurity would no longer place us in the second tier among industrialized nations.

Addressing Society's Problems

In my vision, academic medicine would take a leadership role in addressing a number of the pressing problems of our society. We have been spectacularly successful over the past several decades in marshalling the talents and resources of our entire enterprise to gain fundamental insights into the biology of human disease and to bring those insights to the bedside for the betterment of mankind. Any vision of academic medicine's future would foresee a robust continuation of this crucial mission. But imagine what might happen if medical educators, researchers, and academic physicians joined with equal force in a concerted, coordinated effort to address the blight of substance abuse and drug addiction. Envision the potential benefits if similar concerted and coordinated campaigns by academic medicine were mounted to address teenage pregnancy and societal and domestic violence. It's wrong to think that problems such as these are beyond the collaborative reach of 125 medical schools, 67,000 medical students, 400 major teaching hospitals, over 100,000 residents, 86 academic societies, and 87,000 full-time faculty. Imagine how powerful an impact such a concerted effort would have, and, as an added benefit, how powerful a message we would be sending to our students about the core values of our profession.

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Containing Costs

In my vision, bold leadership by academic medicine would be credited with forcing the costs of health care to rise more slowly than the rate of inflation. I envision this achievement resulting from a multipronged attack on many fronts. For example, medical schools and their associated teaching hospitals and health systems would take the lead for the rest of our society in dealing soberly with the complex tradeoffs that must be made between the costs of health care, on the one hand, and the availability and quality of health care for individuals and for populations, on the other hand. New strategic alliances, such as those called for in the AAMC's strategic plan, would enable us realistically to take on the challenge of educating the public just as well about the *limitations* as we do about the *miracles* of modern medicine.

In my vision, bold leadership by academic medicine would be credited with forcing the costs of health care to rise more slowly than the rate of inflation.

Academic medicine also would greatly expand the forums necessary for serious discussion and would enlarge the proving grounds for experimental programs that would enable physicians and all other health care providers to work out their proper roles and relationships in delivering cost-conscious but effective care. Many turf battles would be resolved, and demonstrated competency and cost effectiveness would become the proper criteria for assignment of responsibility for patient care services. Medical students' and residents' education would occur in close coordination with the education and training of all varieties of health care workers. As a result, physicians would emerge from training with the knowledge and skills required to function collegially as members of multidisciplinary teams.

In line with the AAMC's strategic commitment to champion medical education, faculty would restructure the curricula of medical schools and residency programs to expand the emphasis placed on clinical resource man-

agement. Armed with the lessons of clinical epidemiology, the rigors of decision analysis, and the maxims of evidence-based decision making, physicians would be imbued with a sense of parsimony in utilizing clinical resources, and be equipped with the tools to achieve desired diagnostic and therapeutic goals with the most cost-effective strategies—all the while ensuring that the best interests of patients are always of paramount concern.

Harnessing Information Technology

In my vision, today's leaders of academic medicine, assisted by the AAMC's strategic commitments in the information technology arena, would harness the incredible power of this exploding technology as vigorously as an earlier generation harnessed the power of electricity. Academic medicine would pioneer the development, dissemination, and implementation of comprehensive clinical information systems. These systems would assess—in real time—the outcomes of health care delivered in all settings and would provide the necessary tools for measuring the effectiveness of specific diagnostic and therapeutic interventions. A far cry from models developed by and for the insurance industry to profile physicians' performance for economic purposes, these powerful, new, value-laden systems developed by academic medicine would incorporate sophisticated measures of quality care based on rigorous outcomes data, and, where data were lacking, would embody the best clinical judgments of experienced physicians.

> ***Academic medicine would pioneer the development, dissemination, and implementation of comprehensive clinical information systems.***

Capitalizing further on the immense power of the new information sciences, academic medicine would find ways to deliver its unique expertise and its authoritative knowledge directly to the public. Inundated by the Internet with medical factoids of uncertain reliability from unfamiliar sources, the public would warmly embrace initiatives by academic medicine to provide a believable filter by which to separate real information from electronic snake oil.

Fostering Racial, Ethnic, and Gender Parity

I also envision continued progress towards racial, ethnic, and gender parity in medicine. In my vision, all minority communities would be represented appropriately in the medical profession, because all medical schools would have institutionalized the mechanisms that are leading *Project 3000 by 2000* to meet its goal. By acting on our affirmations, we also would reach the point at which medical school faculties would be restructured to reflect our increasingly diverse and multicultural society. Equally important, women and members of previously underrepresented minority groups would be well in evidence among deans, department chairs, and other key leaders in our medical schools and associated teaching hospitals and health systems.

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Solidifying Status with Policymakers

All of these efforts on behalf of the public would not only help to improve the health status of the American people and to stem the rising costs of health care, they would serve to solidify academic medicine's status among the nation's policymakers and opinion leaders. Having demonstrated that its overarching commitment is the welfare of the public, academic medicine would be less suspect of being self-serving and would shed its reputation for elitism. As a consequence, it would be no accident that Congress would establish the

Having demonstrated that its overarching commitment is the welfare of the public, academic medicine would be less suspect of being self-serving and would shed its reputation for elitism.

dedicated, broad-based funding mechanisms that academic medicine advocates to help meet the costs of clinical training for medical students and residents, and to help support the research infrastructure of medical schools.

Restructuring and Downsizing

No vision of academic medicine's future would be plausible without picturing a significant restructuring and downsizing of our enterprise. In my vision, a restructured academic medicine would be sized and organized in order to maximize the value our students and the public receive from the payments they make for our products and services.

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Helping meet workforce needs. The AAMC's new strategic plan calls for the Association to take a leadership role in helping meet future workforce needs for physicians and medical scientists. In my vision, our country would have far fewer residency programs, and all would be judged by the profession to be of superior educational quality. The capacity to train physicians for the workforce would be calibrated to accommodate all graduates of U.S. medical schools, plus those physicians who were educated abroad, sponsored by their own country, and committed, at the completion of their training, to returning home to improve *their* nation's health care.

Thanks to the effective advocacy efforts of academic medicine, bolstered once again by the AAMC's strategic initiatives, institutions previously dependent on international medical graduates to provide needed services to vulnerable populations would have the resources necessary to wean

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their patient care programs away from their education mission. Thanks also to academic medicine's advocacy, proper financial and other incentives would be in place to encourage physicians to pursue careers in medically underserved areas and to choose specialties closely matching available practice opportunities.

Transforming teaching hospitals. Teaching hospitals, so critical to the education and research missions of academic medicine, are evolving into integrated academic health care systems and reducing sharply the number of acute care beds in their institutions. Notwithstanding this downsizing, their ability to provide appropriate clinical training for medical students and residents and to conduct clinical research would, in my vision, actually be improved over the old model. Being ever mindful of their core education and research missions, the architects of integrated academic health care systems would ensure that their academic missions benefitted appreciably from the availability of a variety of ambulatory care and community-based sites, and from a well-articulated network of practicing physicians and other health care professionals. These systems also would enable academic medicine to pioneer in the development of better models for medical care, stressing value, efficacy, convenience, and patient satisfaction. Such models also would enable academic health care systems to judge their success by measuring the actual outcomes of their diagnostic and therapeutic interventions, and to assess the actual health status of the population for which they assume responsibility.

Academic health care systems [would be able] to judge their success by measuring the actual outcomes of their diagnostic and therapeutic interventions, and to assess the actual health status of the population for which they assume responsibility.

Developing regional education consortia. The development of integrated academic health care systems also would facilitate the creation of regional medical education consortia. These consortia would have responsibility for overseeing the quality of residents' education, for adjusting the number and distribution of training positions in response to evolving regional needs, and for coordinating the education of residents with that of medical students.

Becoming a learning network. Aided by the AAMC's strategic initiatives, and most especially by our new Center for the Assessment and Management of Change in Academic Medicine, academic medicine would become a model learning network committed to continuous improvement. The novel communication techniques and tailored meeting formats, also envisioned in our strategic plan, would ensure that meaningful cross-talk occurs among all segments of the academic medicine community. And a variety of effective means would be employed to disseminate widely the lessons we learn from each other.

Academic medicine would become a model learning network committed to continuous improvement.

Creating a permanent planning process. Recognizing that the needs and expectations of our students and the public change from time to time, leaders of academic medicine would establish a permanent planning process. I envision an ongoing process, emanating from the expanded alliances called for in the AAMC's strategic plan, that would engage experts from within the academic community, representatives of relevant governmental bodies, leaders from the business community, and members of the public at large to monitor the performance of academic medicine and to serve as an early warning system. Those selected to guide this process would be among the most highly respected and experienced individuals in the country. Consequently, their observations and recommendations would be listened to carefully and taken very seriously in the formation of policies and positions for academic medicine.

Final Thoughts

You now have an overview of my vision for academic medicine. Fanciful? I don't think so. Optimistic? You bet. Achievable? Maybe. Do we have the talent to do it? Look around you for the answer to that one. What you see are some of the finest examples ever to emerge from the deep end of the human gene pool. We definitely have the talent to do it. And we know the pathway to take. I'm not talking now about the AAMC's Strategic Plan, although I am convinced that our new plan will help academic medicine move along the right path. The path I am talking about now is the one marked clearly by medicine's tradition of public service and imbedded in our concept of medical professionalism. If we adhere scrupulously to that path, if we let our decisions—about size, about resource allocation, about program offerings, about whom to partner with—flow from our interest in first principles, focusing without compromise on the best interests of our students and the public, dampening the natural temptation to place a higher priority on our personal, institutional, or regional interests, we can travel that principled path to a future every bit as glorious as our past.

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AAMC ASSOCIATION OF AMERICAN MEDICAL COLLEGES
2450 N STREET, NW, WASHINGTON, DC 20037
PHONE 202-828-0400 FAX 202-828-1125